Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3229HPC	A. BUILDING _____ B. WING _____	10/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HOSPICE INC	3675 PECOS MCLEOD, SUITE 900 LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS Surveyor: 27286 This Statement of Deficiencies was generated as a result of a focused State Licensure survey conducted at your agency on October 14, 2009, in accordance with Nevada Administrative Code, Chapter 449, Provision of Hospice Care. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevention of such occurrences in the future. Also, the intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Ten patient records were reviewed. Eleven employee files were reviewed. The following deficiencies were identified:	L 000		
L 064 SS=E	449.0185 REQUIREMENTS OF PROGRAM OF HOSPICE CARE A program of hospice care must comply with the following requirements: 7. Home health aide and homemaker services must be available to each patient and provided at intervals which meet the needs of each patient. A registered nurse must: (a) Supervise the persons providing such services; and (b) Prepare written instructions	L 064		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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L 064	Continued From page 1 for the persons providing such services which identify the duties they are to perform. This Regulation is not met as evidenced by: Surveyor: 27286 Based on clinical record review, policy review and staff interview, the agency failed to provide supervision of the certified nursing assistant at least every 14 days by a registered nurse for 4 of 10 patients (Patient #1, #5, #9 and #10). Severity: 2 Scope: 2	L 064		
L 069 SS=F	449.0186 REQUIREMENTS FOR PLAN OF CARE 2. A plan of care must: (c) State the scope and frequency of each service to be provided to the patient and members of his family. This Regulation is not met as evidenced by: Surveyor: 27286 Based on clinical record review, the agency failed to conduct the maximum number of ordered visits within an ordered visit range for 10 of 10 patients, and in one case, the agency conducted visits that exceeded those ordered for 1 of 10 patients (Patient #8). Severity: 2 Scope: 3	L 069		